 **Consultation Form**

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| Client name: |  |
| Address: |  |
| Date of Birth: |  |
| Telephone: |  |
| Email: |  |
| Occupation: |  |
| Doctors Name and Address: |  |
| In case of Emergency: |  |
| Any known Allergies: |  |
| Any current medication / homeopathic remedies or supplements: |  |
| Could you be / are you pregnant: |  |
| Do you have a history of miscarriage: |  |
| Are your periods regular: |  |
| Are you using a contraceptive: |  |
| Are you on HRT or similar: |  |
| How would you rate your general health: |  |

Please indicate yes or no if you suffer with any of the following:

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| --- | --- |
| Epilepsy / seizures | Thyroid Disorders |
| Stomach issues | Nervous system disorders |
| Immune system disorders | Depression / anxiety |
| Cancer | Kidney Disorders |
| Respiratory system disorders | Diabetes |
| Sensitive skin | Haemophilia / blood thinners |
| Heart conditions | Thrombosis or embolism  |
| High / Low blood pressure | Muscular skeletal disorders |
| Circulatory system disorders | Endocrine system disorders |
| Recent operations | Other |
| If you have answered yes to any of the above please give details: |  |

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| --- | --- |
| Do you have any specific aims or targets for your treatment? |  |
| Treatment: |  |
| Date of Treatment: |  |
| Contra-Indications requiring Medical Referral or Restricting treatment: |  |
| Treatment Details: |  |
| Notes for future treatments:  |  |
| Aftercare advice:  |  |

Here at Simply Be I take your privacy seriously and will only use your personal information to administer your account and to provide the products and services you have requested. Your personal information will be kept for a 7 year period, stored securely and not passed on to any third parties. Please indicate below your preferred methods of communication.

Telephone Email Post Facebook

I declare that the information I have given is correct and I know of no reason why the treatment cannot proceed. I have been fully informed about the treatment, the storing of my data and am happy to proceed with my treatment.

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| Client Signature: | Date: |
| Therapist Signature:  | Date: |

Therapists further Notes: